BRYAN PHYSICIAN NETWORK
2222 S 16TH ST STE 400A
LINCOLN, NE 68502
PERSONAL & CONFIDENTIAL

ADDRESS SERVICE REQUESTED

0101

IF PAYING BY CREDIT CARD, PLEASE CHECK BOX FOR SELECTION AND FILL OUT BELOW.

☐ MASTERCARD ☐ VISA ☐ DISCOVER

CARD NUMBER	VERIFICATION #
CARDHOLDER NAME	EXP. DATE
SIGNATURE	

ACCOUNT NUMBER	DUE DATE	Amount Due	AMOUNT PAID
xxxxxx	Upon Receipt	$25.00	

Pay online now at www.paymydoctor.com Free, Secure, Easy. Please use Client ID-56850.co1

Stmt Date: 01/15/2018

Patient Name
Patient Address

BRYAN PHYSICIAN NETWORK
2222 S 16TH ST STE 400A
LINCOLN, NE 68502

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

TO ENSURE PROPER CREDIT, DETACH AND RETURN TOP PORTION IN THE ENCLOSED ENVELOPE.

Page	Statement Date	Due Date	Office Phone Number	Account #	Patient Balance
1 of 1	01/15/2018	Upon Receipt	(402) 483-8590	xxxxxx	$25.00

Date	Visit Detail	Explanation of Activity	Charges & Debits	Insurance Pending	Payments & Credits	Patient Balance
Patient: Patient Name						
Department: Southeast Lincoln Family Medicine						
Voucher: ########						
12/27/2017		Office Outpt Est Level	$125.00			
01/05/2018		BCBS Payment			-$82.00	
01/05/2018		BCBS Adjustment			-$18.00	
01/05/2018		BCBS Transfer				
		Your Co-Pay is due at time of service. Please remit payment.				
		Visit Total				$25.00

MESSAGE

Thank you for your prompt payment.

BRYAN PHYSICIAN NETWORK
2222 S 16TH ST STE 400A
LINCOLN, NE 68502

Account Number	xxxxxx
Billing Inquiries	(402) 483-8590
Amount Due	**$25.00**

2738-ALLST7-188389-1240315002-; 5977496-1-1280; 1240315002_4; 1

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE . . . .

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE
( )

MARITAL STATUS
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME TELEPHONE
( )

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

PRIMARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME EFFECTIVE DATE

SECONDARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

The purpose of this communication is to collect a debt, and any information obtained will be used for that purpose.